SOUTH CAROLINA DEPARTMENT OF INSURANCE

Mailing Address
P.O. Box 100105
Columbia, SC 29202-3105

Physical Address
1201 Main Street, Suite 1000
Columbia, SC 29201

Phone: 803-737-6180 or 1-800-768-3467
Fax: 803-737-6231
consumers@doi.sc.gov

CONSUMER COMPLAINT FORM

1. Complainant's Information

Name			Email
Street Address			
City	County	State	Zip Code

Phone Number (Where you can be reached between 8:30 a.m. – 5:00 p.m.)

I am filing this complaint as the:
☐ Insured ☐ Producer ☐ Medical Provider ☐ Third Party/Accident Victim ☐ Beneficiary ☐ Other (Please specify)_____

Have you or anyone previously written or faxed to the South Carolina Department of Insurance regarding this complaint? ☐ Yes ☐ No
If yes, when _____

2. Policyholder and Policy Information

Policyholder's Name		Email	
Policy #	Claim #	ID #	Date of Loss
Name of Insurance Company Involved		Phone	
Name of Agent/Adjuster		Phone	

Name of Employer Offering Coverage

Type of Insurance (Check at least one and all that apply)
☐ Auto ☐ Home ☐ Business ☐ Life/Annuity ☐ Credit ☐ Long Term Care ☐ Other (Please specify) _____
☐ Accident/Health ☐ Group Coverage ☐ Individual Coverage

3. Reason for Complaint

(Check at least one or all that apply)
☐ Claim Delay ☐ Claim Denial ☐ Agent Handling ☐ Cancellation ☐ Premium Problem ☐ Premium Refund
☐ Unsatisfactory Offer ☐ Non-Renewal ☐ Other (Please specify) _____

(If applicable, check all that apply)
Discrimination based on:
☐ Race ☐ Color ☐ Sex ☐ National Origin ☐ Age ☐ Location of Residence ☐ Income Level ☐ Marital Status ☐ Ancestry

4. Attorney Information

Does an attorney represent you? ☐ Yes ☐ No
If you answered yes, please provide the name of the attorney and their phone number below.

Name of Attorney	Phone

5. Below, please describe in detail your complaint and what you consider to be a fair resolution to the complaint.
This form and COPIES of important papers or other supporting documentation as it relates to this complaint should be submitted to the Department by email, fax or US Mail. If your complaint is being mailed, do not send any original documentation.

(Please use additional paper if necessary.)

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Consent to Release Information: The information I have given above is true and accurate to the best of my knowledge. This information may be forwarded to the insurance company, if necessary for the investigation of this matter. I understand that under South Carolina's Freedom of Information Act this complaint becomes a public record once my file is closed. (Medical and personal records will remain confidential).

☐ By checking this box and/or submitting this form electronically to the SC Department of Insurance, I authorize the Department to pursue resolution of my complaint.

Signature	Date

Disputes involving Self-Funded Employer Benefit Plans come under the jurisdiction of the United States Department of Labor. 1-866-275-7922
South Carolina State Employees or Retirees medical, dental, disability and long term care issues come under the jurisdiction of the SC State Insurance Plan. 1-888-260-9430 or 803-734-0678.